ARKANSAS CHILD FATALITY REVIEW 2009

PREPARED FOR:
ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILDREN AND FAMILY SERVICES

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INTRODUCTION

The Arkansas Division of Children and Family Services (DCFS) reviews reports on all deaths from all causes of children with whom the agency has been involved in any way during the 12 months prior to the child's death. Such a review does not include all child fatalities due to abuse and neglect. Indeed, over the past five state fiscal years 68 percent of abuse and neglect fatalities in Arkansas had had no previous history with DCFS. Nor is the population on which DCFS must report limited to children who died from abuse and neglect. As will be seen in the following pages, many if not most died from other causes.

The purpose of this report, "Arkansas Child Fatality Review 2009," is to analyze all the information available from the reviews of the 29 applicable cases conducted during state fiscal year 2009 to determine whether lessons can be learned to guide future DCFS practice and ultimately to reduce the numbers of child fatalities. These reviews were originally conducted by the Child Death Review Committee of the Division of Children and Family Services.

Many of the cases examined in this report involved past referrals of abuse and neglect which were found to be either unsubstantiated or true after being investigated by the agency. DCFS defines abuse to include any non-accidental physical injury, a serious threat of a serious injury or death, and any injury to the child's intellectual, emotional or psychological development. Neglect includes failure to provide a child with the necessary food, clothing, shelter, education or medical attention; failure to take reasonable action to protect the child from any form of abandonment or abuse; or failure to assume responsibility to care for the child. These definitions state that the abuse or neglect must be caused by the person responsible for the child.

An allegation of abuse or neglect will be found true after investigation if there is a preponderance of evidence to support it. An unsubstantiated allegation is one in which there is not a preponderance of evidence. Definitions, as defined in DCFS policy, for the terms abuse, neglect, true and unsubstantiated are included in Appendix A.

Physical abuse and neglect are among the top four reasons that children were placed in foster care during the state fiscal year 2008, as reported in the Annual Report Card for 2008. What may be surprising is that over twice as many (26%) were placed for neglect than for abuse (10%) during fiscal year 2008. Seventeen percent were brought into care due to parental substance abuse and another eleven percent were due to parent incarceration. The remainder had a variety of other reasons for placement.

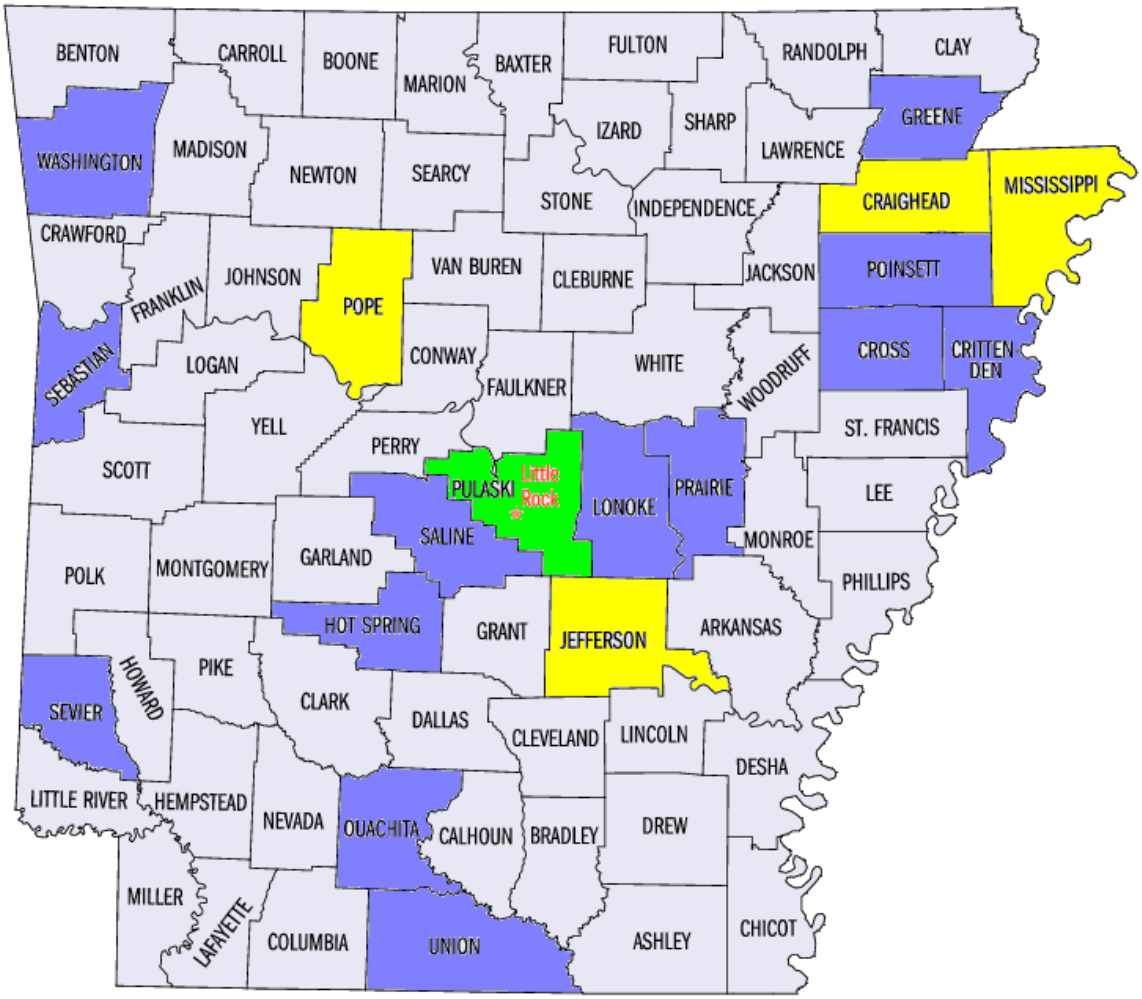
In the event of a fatality or near fatality of a child or a sibling involved with DCFS or previously involved within the last 12 months, DCFS convenes the Child Death Review Committee for the purpose of reviewing DCFS actions and previous involvement and to recommend appropriate actions for the future. The committee consists of

representatives from policy, training/staff development, the field, the Community Services Central Office and the Office of Chief Counsel as well as the Deputy Director. Through the internal death review, the committee reviews the case in its entirety identifying any of the potential issues of the case, including what DCFS did right and possibly wrong in each case. Cases are then provided to the External Death Review Committee for review. The Committee recommends to the Director appropriate actions as deemed necessary and desirable to protect other children in the home or to take other corrective actions.

The child deaths reported to the federal Administration for Children and Families (ACF) through the National Child Abuse and Neglect Data System (NCANDS) are of a different size and scope than those reviewed by DCFS. NCANDS requires key demographic data on children where abuse or neglect was a contributing factor to the death. Those children who died of an illness or an accident, for instance, will not be included in the federal review even when previously known. Therefore, ACF will likely require information on fewer children. The DCFS review is not limited to child deaths involving abuse and neglect but does focus on the children who have had any contact with DCFS in the past 12 months. Moreover the DCFS review is far more comprehensive, allowing DCFS to take a harder look at the specifics of each fatality for children known, either currently or in the past, to DCFS. The dates of the two reports are different as well, with DCFS examining all the children who died in state fiscal year 2009 and the federal report examining children whose death was reported during the federal fiscal year, October 2007 to September 2008.

As mentioned above, there were 29 child deaths meeting the state's criteria for review by the Child Death Review Committee in state fiscal year 2009. Twelve of those cases involved current or past protective services cases and seven involved current or previous foster care cases. One child was in a pre-adoptive home and one was in an adoptive home at the time of death and eight had no previous case opening for services. Six of the 29 cases involved deaths prior to state fiscal year 2009; however, the new internal death review procedure was used for these cases.

Child Deaths by County, 2008



The map represents counties in which at least one child death occurred. Blue counties indicate one child death, yellow counties indicate two and the green county indicates three or more deaths (7). One death occurred in Indiana State and is therefore not represented on this map.

In seven of those 29 cases, the cause of death was clearly child abuse. Each of the seven was the result of violence against the child.

In ten of the 29 cases, the child's death was just as clearly *not* the result of abuse or neglect. A few of these children were seriously physically ill and in at least some cases the death was expected.

In the remaining 12 cases the cause of the child's death was unknown. At least half of these were actual or suspected instances of sudden infant death syndrome (SIDS), but

in some cases the death review conducted by DCFS simply lists the cause of death as undetermined.

This category is obviously the most difficult with which to deal. In some instances there was a formal determination made that the parents or other caregivers were not at fault; in others that appears not to have occurred. If maltreatment was involved, it was almost certainly neglect rather than abuse, and while in some cases there may have been culpable carelessness, but there was fairly clearly no intent to harm the child. For instance, the autopsy report for a SIDS death generally indicates possible SIDS as a cause of death and a few of these cases involved co-sleeping arrangements that could have contributed to the child's death.

For the purposes of this analysis, the cause of death in these cases is categorized as "unknown." At the same time, without making a judgment as to whether the caregivers were negligent, the dynamics of these cases are assumed to be similar to the dynamics of neglect cases. The ambiguity in their treatment here mirrors the ambiguity of the cases themselves.

As will be seen in the following pages, these three groups are different in more ways than just the cause of death. The intent of this report is to analyze these cases in an attempt to identify anything DCFS might be able to do to reduce the number of child deaths in the future. There are, however, at least three reasons to be cautious about any results that come from the analysis.

First, in most of these cases the actions of DCFS caseworkers were not contributing factors which resulted in the children's deaths. That means that if the agency is to be successful at preventing more than a few of these deaths, it will not only have to improve its own performance but it will have to invent new ways to identify and deal with the threat of death to a child. While much research has been done to find patterns among child fatalities, there is as yet no reliable predictive tool.

Second, the numbers with which this analysis deals are very small. The analysis will show, for instance, that nearly three-quarters of the children who died from abuse were girls, but if only one of those children had been a boy instead of a girl, the percentage of girls would have dropped to 57 percent. Small numbers are subject to large swings and need to be interpreted carefully because next year's numbers could be quite different.

Finally, and perhaps most importantly, the results of this analysis have to be used with care because the analysis is, by its very nature, retrospective. Instead of taking a population and following it forward into the future to see how different subgroups within the population end up in different places, this analysis starts with a population who all had the same end result and seeks to find commonalities in their pasts. The danger can be illustrated by an example. Most people who use illegal drugs began drinking alcohol before they began using the drugs. We do not, however, conclude that most people who drink alcohol also use illegal drugs or that we should ban alcohol in order to prevent illegal drug use. Similar restraint will be needed in interpreting the results here.

The success of any human service intervention is ultimately dependent on two sets of factors: the characteristics of the clients with whom the agency is working and the characteristics of the intervention. For the purposes of this analysis, the categorizations of client factors need to break into at least two further groups: characteristics of the child and characteristics of the parents or other protectors of the child. The analysis begins, therefore, with a discussion of the characteristics of the children. That will be followed by an examination of the characteristics of their parents and, where appropriate, the perpetrators of the maltreatment leading or potentially leading to their deaths. Finally, intervention characteristics will be examined, meaning that the focus will shift here to what the agency did and how well it did it.

INFORMATION SOURCES AND METHODOLOGY

Three sources of information have been utilized for this report. The first is the death reviews DCFS conducts to comply with state and federal reporting requirements. The review team examines all of the information available from all sources, including police reports and autopsy findings. The reports emerging from the team's review of each case was the starting point for the analysis here.

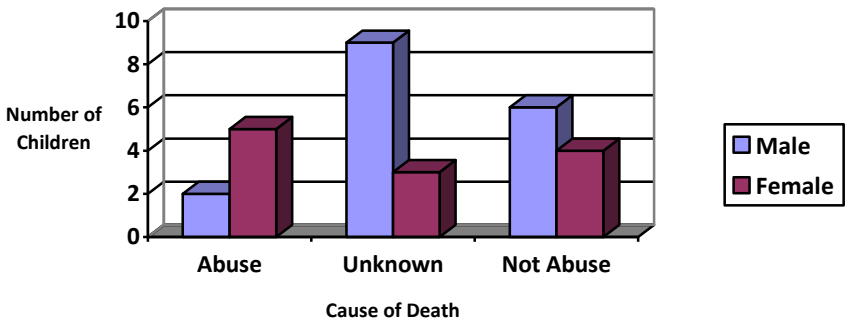
Some of these reports, however, did not contain as much information as did others. For instance, while the review team undoubtedly reviewed police reports and autopsy findings when they were available and used them to draw their conclusions, these materials were sometimes not included in the materials provided for this review. While summaries of the findings were included, they did not always reveal their conclusions.

For this reason if no other, the analysis also utilized information on the individual cases from CHRIS, the state's child welfare information system. Because the criterion for selecting cases required some previous contact with DCFS, CHRIS had some level of information on all of them. Both the amount and the direct relevance of that information varied widely, depending on the nature and length of the family's history with the agency. Nevertheless, CHRIS was an essential tool in collecting information that was not in the paper record provided by the death review team. Restructuring the form used to capture information on each related case which also documents the contents of the paper record would serve as a means to ensure the documentation is complete for a more thorough and comprehensive review.

CHRIS also represented the third source of information for this analysis, but used in a different way. Because of the small numbers and the potential for each year's data to be completely idiosyncratic, analyses were conducted summarizing the characteristics of all the fatality cases recorded in CHRIS over the last five state fiscal years, i.e., SFY 2005 through SFY 2009. Because many of these cases had no previous involvement with DCFS and because many of the cases analyzed for this review were not recorded in CHRIS as child abuse and neglect fatalities, the two populations overlap but are far from identical. Nevertheless, having the comparisons provides both a reality check on the analysis and a means of articulating the differences between the population studied here and the population normally included in analyses of child welfare deaths.

That the three groups of cases described in the introduction differ from one another appears even in the demographic characteristics. Figure 1, for instance, shows the gender breakdown for each group. While the majority of the children who died from abuse were girls, the majority of those whose causes of death are unknown were boys.

Figure 1
Gender by Cause of Death

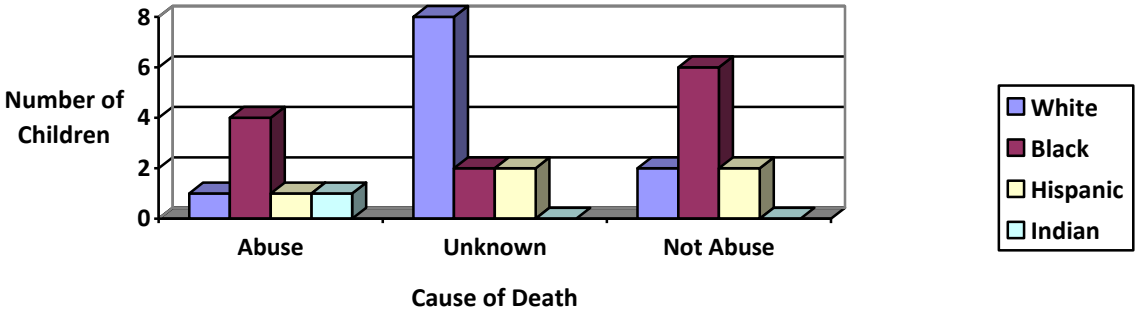


Similar disparities show up in relation to race and ethnicity. Figure 2 shows that among both the children who died from abuse and those who clearly died from something other than maltreatment, the majority were African American. Among those where it is unknown whether the death was caused by maltreatment, the majority are White.

Because of the preponderance of White children among the cases where the cause of death is unknown, the racial proportions are noticeably different among the groups analyzed here from those involving all of the fatalities recorded in CHRIS over the past five years. Among that population barely half of the children were White. Here, after excluding cases where abuse or neglect was clearly not the cause of the child's death, there are twice as many White children as African American children.[1] The gender distribution among the children analyzed here, on the other hand, is quite similar to that found for all fatalities recorded in CHRIS over the past five years.

[1] This includes the children listed in this table as Hispanic because all of those children were White and would have been recorded as such in CHRIS.

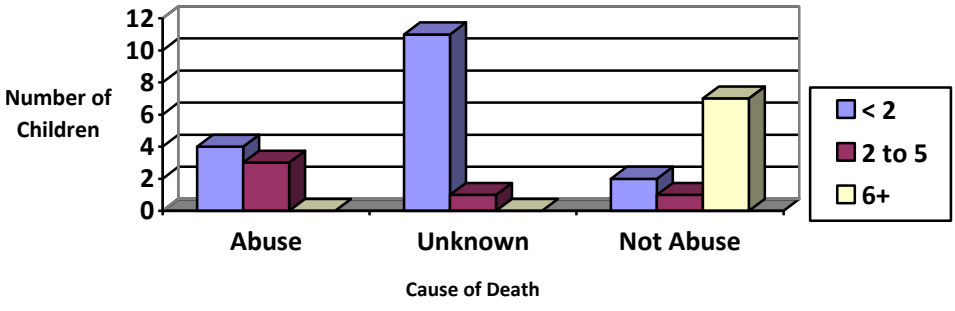
Figure 2
Race and Ethnicity by Cause of Death



Perhaps the most interesting and meaningful demographic differences among the three groups have to do with age. As shown in Figure 3, among those who died from violent abuse, all were under the age of six and a slight majority were under the age of two. Among those where maltreatment may or may not have been the cause of death, not only were all the children under the age of six, all but two of the 12 were under the age of one. One child was one and one was three years old. Combined, these proportions are very close to those reported in CHRIS for child fatalities. Over the past five state fiscal years, 72 percent of the children were 0 to 3 and another nine percent were four to six.

The group of children who died from causes other than maltreatment shows their differences more clearly in relation to age than to any other demographic factor. A slight majority of these children were six years of age or older. In fact, all of those six years of age or older were teenagers, and one was even 19, technically an adult but still within the range of ages handled by DCFS.

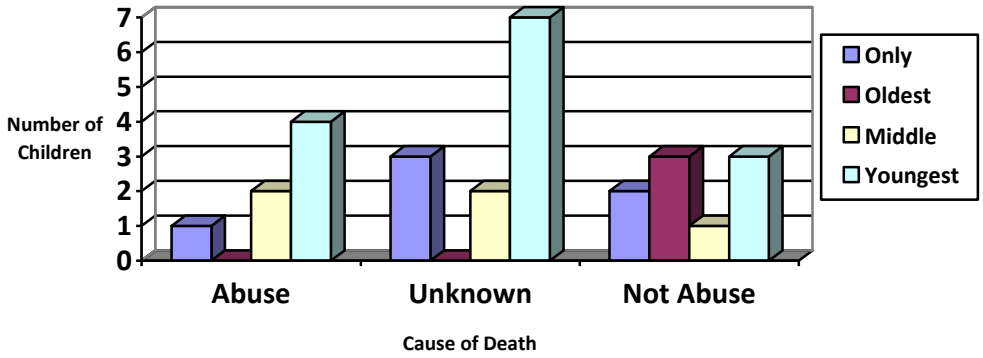
Figure 3
Age by Cause of Death



Beyond the normal demographics factors of gender, race and age, birth order is sometimes considered to be a significant factor in determining the level of threat to a child. Like age, this is a factor on which the "abuse" group and the "unknown" group come close to matching one another. As shown in Figure 4, for both groups the majority of the children were the youngest child of two or (usually) more children in the family. A few were "middle" children and the rest were only children. None of the children in either of these groups was the oldest child with other children in the family. These figures are generally consistent with those reported in a 2008 Colorado study which served as the impetus for this report.[2] In contrast, for those analyzed here who died of causes other than maltreatment, oldest children and youngest children appear equally often and together comprise three-fourths of the cases.

Because most of the fatalities recorded in CHRIS over the past five years had no history with DCFS, comparable figures are not available for all of those cases. For those with such a history, however, 62 percent were the only child and 24 percent were the youngest of two or more children. While this is a different distribution than the one seen here, it still shows the predominance of the same groups: only children and youngest children.[3]

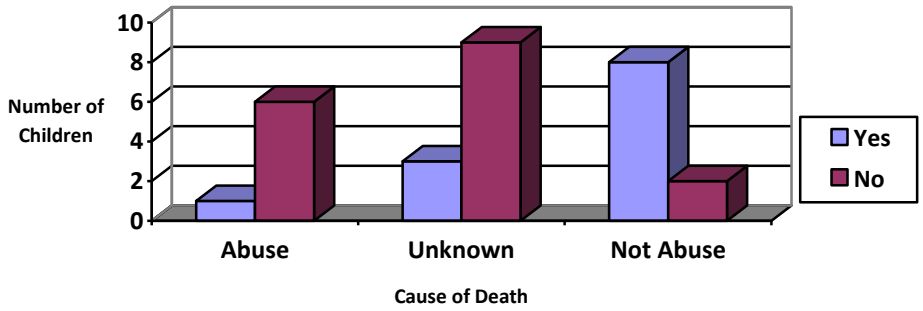
Figure 4
Birth Order by Cause of Death



The final child characteristic which needs to be examined relates to the health of the child. This is potentially important not only because health issues represent one of the most frequent causes of death for the population on which DCFS must report, but also because serious health issues may demand more care than some parents are capable of providing and almost always place additional stress on the family. Figure 5 shows that the groups differ among themselves in roughly the ways one would expect.

[2] Colorado Department of Human Services, Administrative Review Division, *Child Maltreatment Fatality Report 2007*. Retrieved from http://www.cdhs.state.co.us/pdfs/Child_Maltreatment_Fatality_Report_rev_04-30-08.pdf.
[3] There was one child for whom the record did not indicate birth order.

Figure 5
Child Health Issues by Cause of Death



Among the children who died for reasons other than maltreatment, eight had serious health, developmental or mental health issues, and these led directly to their deaths. Of the other two, one was murdered by an ex-boyfriend and one died in a motorcycle accident.

Only a minority of either of the other groups show children with serious health issues. The group where the cause of death is unknown shows a somewhat greater proportion of children with health issues, and that is undoubtedly one of the reasons some of these cases are in the unknown group.

While no single profile can be drawn for any of the groups, selecting the most frequent of each of the above characteristics begins to illustrate how the groups differ. Table 1 summarizes those characteristics.

Table 1
Summary of Child Characteristics by Cause of Death

	Abuse	Unknown	Not Abuse
Gender	Female	Male	Either
Race/Ethnicity	Black	White	Either
Age	Under 2	Under 2	Teenager
Birth Order	Youngest	Youngest	Youngest or Oldest
Health Issues	No	No	Yes

PARENT/PERPETRATOR CHARACTERISTICS

While the analysis of fatality cases generally places focused attention on the child's parents, an examination of the three groups included here suggests that a somewhat more nuanced approach is needed. In particular, there is a stark contrast between the cases in which abuse was clearly the cause of death and the cases in which the cause may or may not have been neglect. Among the seven abuse cases, the perpetrator was a parent in two of the cases. Three of the perpetrators were live-in boy- or girl-friends (two male and one female), one was a foster parent and one was a pre-adoptive parent.

In the cases where the death may have been caused by neglect or may have been either natural or accidental, no one is formally designated as a perpetrator. Examination of those cases, however, indicates that in nearly all of them, it was a parent who was at fault, if anyone was. This suggests two points. First, the dynamics surrounding abuse fatalities are almost certainly quite different than those surrounding neglect fatalities, and solutions designed to address one of these issues may not have a lot of impact on the other. Second, it is probably much more important to examine the background of the parents of children in the cases where the cause of death is unknown than it is in cases where the cause was abuse.

That said, there are a few things which appear significant when the characteristics of the adults are taken into account. First, among the 29 cases there were three involving foster and/or adoptive parents. One of these was a foster father who beat a five year-old child, resulting in the child's death. One was a pre-adoptive mother who shook a child to death. One was an adoptive family in which a child was accidentally strangled by a car window a month after finalization of the adoption.

Noting the foster/adoptive relationship of the deceased child to the responsible adult is important because it suggests that the agency's dealings with the child's birth family is of limited if any relevance to understanding the deaths of these children. Agency actions or decisions may be important, but they would be actions and decisions having to do with studying and approving the foster or adoptive parents or with the matching of the children to those parents.

The foster father and the pre-adoptive mother were similar in two respects. Both had only recently been recruited and approved, and both had siblings placed in the home. In addition, all three foster or adoptive homes had enough children in the homes to raise questions about the parents' ability to care for all the children. In particular, it appears as though the pre-adoptive mother who shook the child to death had expressed concern about accepting as many children as she ultimately did.

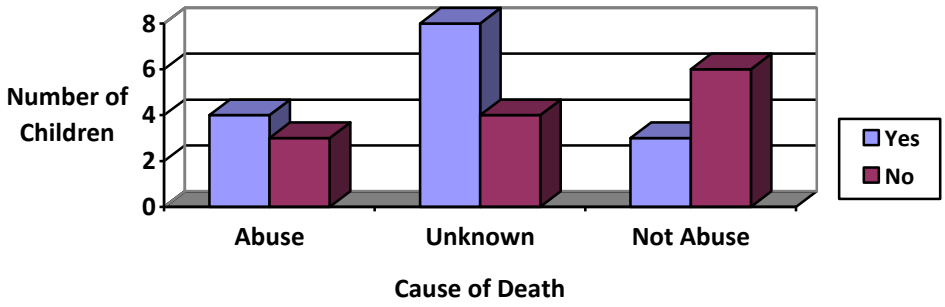
For situations where the child's birth parents are the relevant adults, being a teenage parent is often viewed as increasing the potential for inadequate parenting, and one

might expect to see a significant number of teenage mothers in one or more of these groups. In fact, among all fatalities recorded in CHRIS over the past five years, one in four mothers of the deceased children were teenagers at the time of birth. However, for the population under study here, no relevant age pattern shows up. Very few of the parents were under 20 at the time of the child's birth, and that is consistent with the high proportion of "youngest child" among the fatalities. The one pattern that does appear here is that the parents, and in particular the fathers of children who died because of health or accident reasons not related to any kind of maltreatment, were slightly older than parents in either of the other groups. That, however, does not have any obvious relevance to the effort to reduce future child deaths.

Examination of other parent characteristics is more suggestive, if not conclusive. As shown in Figure 6, all three groups had cases where parental substance abuse was an issue but more so in the cases involving abuse and where the cause was unknown. This is not overly surprising, given the emphasis DCFS places on substance abuse when conducting assessments. These are all cases where DCFS was involved and substance abuse is often a reason for agency involvement.

Still, there are differences among the groups. Among cases where the cause of death is unknown, twice as many parents showed evidence of substance abuse as did not. That compared to only a third of those where maltreatment was not the cause of death and a bare majority of those where abuse was the cause.

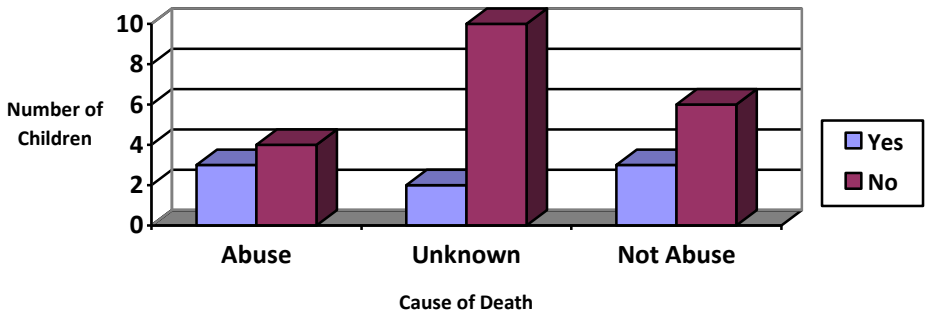
Figure 6
Substance Abuse Issues by Cause of Death



When attention turns to the percentage of families in which domestic violence occurred, see Figure 7, the families where children died due to something other than maltreatment looked the same as they did for the substance abuse question, i.e., nearly one-third showed evidence of domestic violence and the rest did not. The picture was, however, dramatically different for the cases where the cause of death was unknown. Here, only

two of the 12 cases indicated a history of domestic violence, an even lower percentage than among those where maltreatment was clearly not the reason the child died.[4]

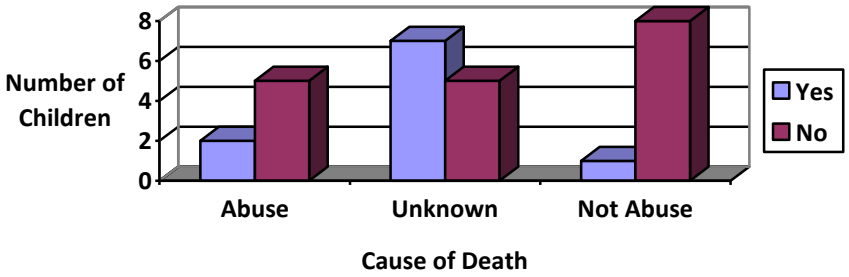
Figure 7
Domestic Violence by Cause of Death



Even for the cases where violence caused the child's death, domestic violence was slightly less likely to be present in the home than was substance abuse. Again, however, the number of cases is so small that the figures could be precisely the opposite a year from now.

The last parent characteristic of interest here is the parents' child welfare history as a child rather than as a parent, as shown in Figure 8. In other words, the question is the extent to which fatalities are a consequence, at least in part, of multi-generational maltreatment.

Figure 8
Parent Abused as Child by Cause of Death



[4] Data are available in CHRIS regarding substance abuse and domestic violence for the fatality cases from the past five years which had a previous history with DCFS and for whom a Family Services Needs and Risk Assessment had been completed. This is, however, a relatively small number of cases and the very low reporting of both substance abuse and domestic violence issues on these forms suggests that their incidence was severely underreported. For that reason no comparison is made here.

The only group where this year's data suggest that multi-generational maltreatment may play a role is the group where the cause of death is unknown. Seven out of those 12 cases showed evidence of abuse or neglect of the parent when the parent was a child, compared to one in nine of those where maltreatment was not the cause of death and two of seven among those where the child suffered a violent death through abuse. It should be noted, however, that past history for the parents of the children examined is limited to the information contained in CHRIS[5].

Table 2 summarizes the parent characteristics as Table 1 did for the child characteristics.

Table 2
Summary of Parent Characteristics
by Cause of Death

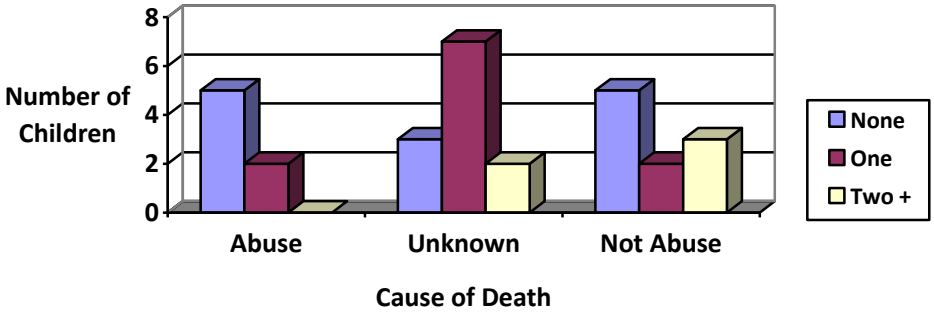
	Abuse	Unknown	Not Abuse
Mother's Age at Birth	15-22 (Median: 22)	20-35 (Median: 22)	16-30 (Median: 26)
Substance Abuse	Yes	Yes	No
Domestic Violence	No	No	No
Abused as a Child	No	Yes	No

[5] There was one child for whom the record did not indicate parental history.

The criterion for including cases in this review was that there had been some contact with DCFS within the 12 months prior to the child's death. The nature of that contact ranged from one family having been reported for abuse for the first time a couple of days before the child died in a motorcycle accident to virtually lifelong involvement with DCFS of a 16 year-old child and her family.

In only one of the three groups analyzed here had a majority of the cases not experienced a "true" report of abuse or neglect during their history of contact with DCFS. Ironically, that one was the group of cases where abuse was clearly the reason for the child's death. That was also the only group which showed no cases with multiple true reports for any of the families as reported in Figure 9.

Figure 9
Previous True Reports by Cause of Death



The cases where the cause of death is unknown exhibited the largest proportion of cases with true reports. It is clearly easier for workers to make definitive decisions for allegations of abuse – was the child physically or sexually abused. It is more difficult for workers to make decisions involving allegations of neglect. For example, if the parent is alleged to have neglected the child for medical reasons, at what point does that neglect of medical care cause harm to the child? To take this one step further, if a parent decides to cease giving a child prescribed medication for ADHD, to what extent is the child at harm and what constitutes that harm has in fact been done? When the child is unable to focus when in school? When the child's grades suffer? However, as noted earlier, most cases involving the removal of a child are opened due to neglect.

While nearly half of the 29 cases under review had no true report in their histories, just over half had no unfounded report. Those least likely to have an unfounded report were the same as those most likely to have a true report, the cases where the cause of death was unknown. Those most likely to have multiple unfounded reports were those in which the child died for reasons clearly unrelated to abuse or neglect. Figures 10 and

11 depict report histories, the first focusing on unfounded reports and the second on total reports.

Overall, six of the 29 cases had no true and no unfounded reports. This included the case in which the only report and only DCFS contact was a report of abuse two or three days before the child was killed in a motorcycle accident and before DCFS had had a chance to investigate the allegation. It also included, however, situations in which the child's death occurred in a foster or adoptive home which had never been reported for anything and one instance in which DCFS opened a case and took the children into care because of a mother's expressed fear that she would harm the children.

Figure 10
Previous Unfounded Reports by Cause of Death

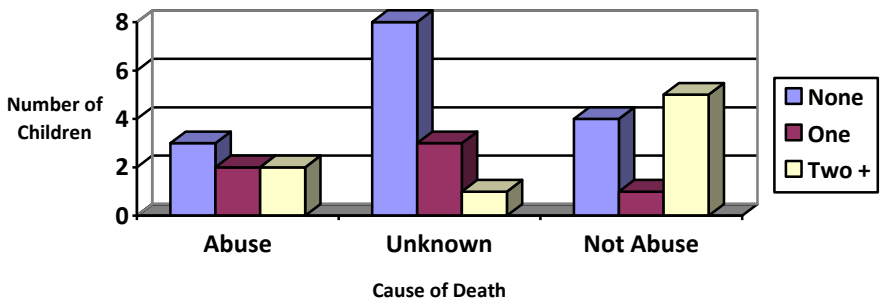
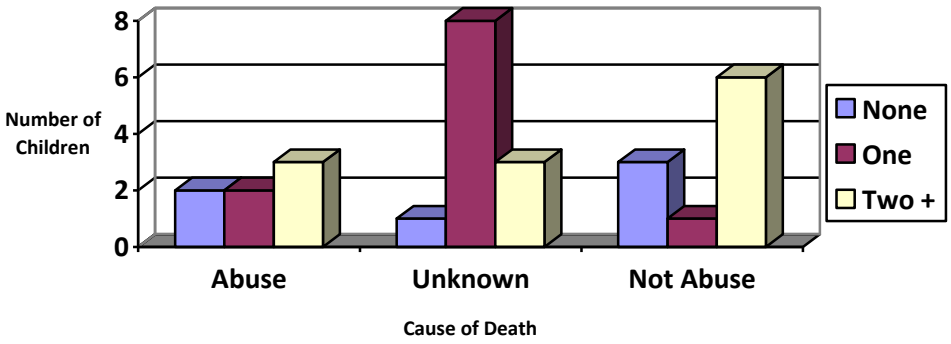


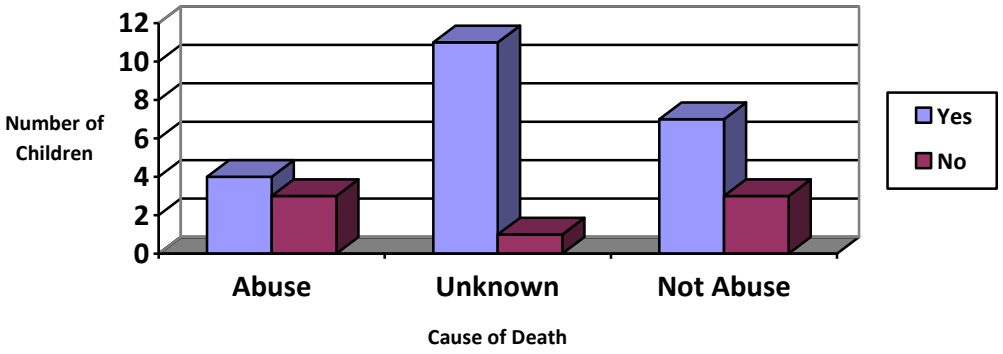
Figure 11
Total Previous Reports by Cause of Death



The cases where the cause of death is unknown were the ones for which DCFS is most likely to have opened a case and provided services. Only one of the 12 cases in that group had not had an open case. In contrast three of the four cases in which the child's death was clearly due to abuse had had no case opened. Even the families where the

child's death was due to health reasons or an accident showed a greater likelihood of having had a case opened.

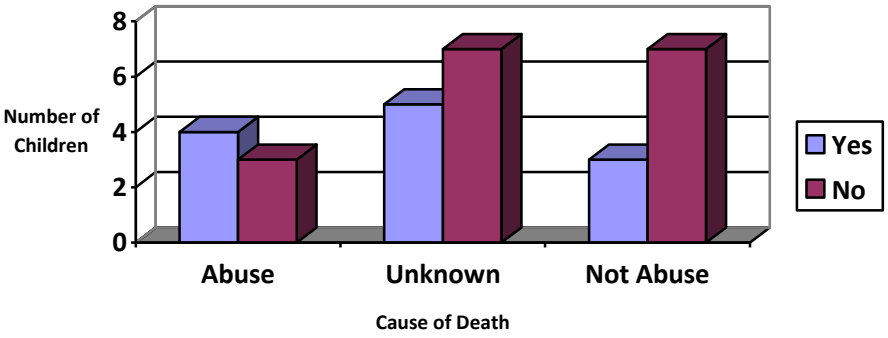
Figure12
Case Ever Opened Prior to Death by Cause of Death



Aside from the question of whether and how DCFS intervened in the case, the question of the quality of that intervention needs to be addressed. One issue to examine is the qualifications and workload of the staff assigned to handle the case. It was not possible to identify all workers involved in these cases, and for about half of them no case and no investigation was open at the time of the child's death.

By conducting the internal death reviews, the agency becomes aware of areas of casework practice that need to change or need to be strengthened, as shown in Figure 13. Regardless of the workers' position or time in the position, for nearly half of the cases there are reasons to question the quality of the work. Most, but not all of these reasons involve DCFS and its actions and judgments. In two instances, the issues had to do with questionable actions by others outside the agency.

Figure 13
Policy/Practice Issues by Cause of Death



There were some cases in which DCFS workers made decisions which, at least in retrospect, could have been improved. There are other cases where decision-making might be improved but did not appear to have any impact on the child's fate. Communication between DCFS and the state police, as well as among counties, seems to have played a role in a few of the cases. In others, the length of time to make contact with families in need of services and open cases for services, including the development of case and safety plans, had an impact.

Given the relatively small number of cases reviewed here and the even smaller number which involved maltreatment as the cause of death, it would be presumptuous to call the impressions which follow here "conclusions." They are perhaps better thought of as hypotheses which may be subject to change or indeed validation through future research.

Some of the hypotheses emerging from this analysis are, however, obvious and have been repeated in every review of child fatalities undertaken. The first has to do with the vulnerability of young children. Children who die from maltreatment, whether from the violence of abuse or the subtler effects of neglect, are almost universally pre-school age. If the cases examined here are typical, one can go a step further and say that infants, those under one year of age, are more subject to death by neglect, while abuse is more likely to occur with toddlers.

The second issue has to do with the cooperation and communication between different units, whether those be inside DCFS or across agencies. Some of the more flawed cases of decision-making involved instances where the state police were responsible for responding to the report, and there were failures on both sides. Transfers across counties within DCFS sometimes appeared to be almost equally problematic. Whether the collaboration is supposed to occur within or across agencies, its absence means delays in responding to the needs of children and families or even to the case falling entirely through the proverbial cracks.

That leads to the third important hypothesis. When casework decision-making, family assessment or agency action was deficient, it was because too little was done. That does not mean that too few children were removed from their homes or that too few families had cases opened with DCFS. Instead, it means that sometimes when caseworkers investigated allegations they did so within very narrow frameworks, looking only at the single incident in isolation from any history within the family. It means that some decisions were made in formulaic fashion and without any deeper assessment of the circumstances of that specific child and family. Improved communication with state police investigators, continued support of families after implementation of safety plans and further address of family issues are examples of actions caseworkers can take in the future to improve their decision-making.

Fourth, as was noted at the outset of this report, issues of abuse and issues of neglect seem to be different. Neglect cases had longer histories with DCFS than did abuse cases, both in terms of the number of previous reports and in terms of previous case openings. Abuse cases were less likely to have had previous true reports than even cases where the child's death was not due to maltreatment at all. In general, the rate of re-neglect is higher than that of re-abuse and abuse and neglect investigations need to be examined differently. The definition of neglect involves the failure of a parent to

protect a child. Given this definition, cases involving neglect can be more subjective than those involving abuse.

What will work to reduce abuse or fatalities from abuse is not likely to be effective in families where the primary danger comes from neglect, and vice versa. That means there cannot be one solution which gets applied to all situations; families have to be assessed in ways that take account of their specific circumstances and interventions have to be directed towards their specific needs.

Finally, it is important to note one significant commonality between child death cases involving abuse and those involving neglect or the less clear causes cited in several cases here. *That commonality is the need for an adult capable of protecting the child.* The failure of the parents, to the extent there was one, in the cases where the cause of death was ambiguous, was a failure to take sufficient care to protect the child. Even in the abuse cases, however, where it was generally not the parent who committed the abuse, it was usually the parent who allowed the abuse to occur. That, too, implies the need for a deeper look at the family's capacities, a look which assesses not only the dangers but also the capacities and lack of capacity for protecting the child.

Related to formulaic decisions already discussed above, often when an investigation is conducted, the caseworker's primary objective is to ensure that those who may harm the child are removed from the situation instead of ensuring that there is an adult present who will protect the child from harm. For instance, this is seen in cases in which a significant other harms a child and then a safety plan is put into place or the offender is removed from the home situation, but the child is subsequently killed because the safety plan was not enforced or the next significant other who enters the home has a similar problem; both result from the lack of a protective adult in the home.

Casework supervision is another important factor. Supervision is closely tied to decision-making, assessment and agency action as supervisors sign-off on virtually every action taken or decision made by a caseworker conducting an investigation. Strong supervision is a key to thorough casework practice. By regularly reviewing investigations, supervisors can ensure that all the appropriate family members and collaterals are interviewed in order for the caseworker to make an informed decision about a case. However, it seems that supervisors are sometimes signing off on investigations that were not thoroughly assessed, allowing for narrow focus and formulaic decisions to be made.

Arkansas' practice allows for a more comprehensive analysis of the family through the Family Strengths, Needs and Risk Assessment (FSNRA). While the tool is not used until after the decision has been made to open the case and provide services, if done properly, the FSNRA should help caseworkers and supervisors to avoid tunnel vision and view the family more holistically.

To the extent that these hypotheses accurately reflect reality, they suggest the following implications for casework practice and actions on the part of DCFS.

- **DCFS should re-examine working relations with law enforcement, particularly at the local level.** The collaboration between law enforcement and DCFS and between county offices within DCFS needs to improve in substantive, not bureaucratic, ways. Dual responsibility cannot be an impetus for each side to be less vigilant on the grounds that the other one is taking care of things.

- **Case practice decision-making needs to become more thoughtful and less formulaic**. There appears to be a direct and formulaic correlation between bruises and true findings of abuse. Bruises ought to be a reason to look more closely at the situation, especially when they involve very young children, but it is the situation as a whole which should guide agency action. DCFS needs to take a more thorough and holistic approach to analyzing the family situation and determining how to proceed. Making better use of tools such as the FSNRA should help in this effort.

- **DCFS needs to be more vigilant in ensuring that safety plans are enforced.** This generally implies assuring that a family member is present who will take responsibility for protecting the child from harm. In many of the cases there appears to be an assumption that if a safety plan exists, the child is safe and no action needs to be taken to ensure that the safety plan is really being carried out. However, the protection of the child needs to be ensured and assessed by further involving all family members. Removing harmful people from a situation or putting a safety plan in place are often not enough when there is no adult in the family to protect the child from harm or enforce the safety plan.

- **Supervision needs to be improved to ensure that decision-making, assessment and actions are appropriate**. Cases of abuse and neglect require a safety net not just for the family but also for the agency. That is, the frontline worker needs support both to assure that the job is getting done and in the judgments that are being made. Supervisors need to be more pro-active in assessing casework practice, questioning decisions, and assuring that the intent of the safety plans and case plans is being carried out in practice.

- **DCFS needs to think clearly and concretely about the differences between abuse and neglect and the practice implications.** Child protection cases are not all of the same type and they do not all exhibit the same dynamics. Only a quarter of the child deaths investigated for this report were the result of physical abuse. A higher proportion of children in foster care have neglect than abuse as the primary reason. Long-term neglect can be as lethal as short-term abuse. Until these dynamics are better understood and acted upon, the system will struggle to be effective. As part of that effort the agency should re-design the death reviews dealing with cases of potential neglect, so that the special dynamics of those cases become better understood.

Appendix A: Definitions

Definitions as defined in Arkansas' Division of Children and Family Services' Family Services Policy and Procedural Manual, Rev. 06/2009. Glossary, 02/2008.

ABUSE -- Any of the following acts or omissions by a parent, guardian, custodian, foster parent, person eighteen years of age or older living in the home with a child whether related or unrelated to the child, or any person who is entrusted with the juvenile's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, childcare facility, public or private school, or any person legally responsible for the juvenile's welfare, but excluding the spouse of a minor:

- Extreme or repeated cruelty to a juvenile;
- Engaging in conduct creating a realistic and serious threat of death, permanent or temporary disfigurement, or impairment of any bodily organ.
- Injury to a juvenile's intellectual, emotional or psychological development as evidenced by observable and substantial impairment of the juvenile's ability to function within the juvenile's normal range of performance and behavior.
- Any history that is at variance with the history given.
- Any non-accidental physical injury.
- Any of the following intentional or knowing acts, with physical injury and without justifiable cause:
  (1) Throwing, kicking, burning, biting or cutting a child.
  (2) Striking a child with a closed fist.
  (3) Shaking a child.
  (4) Striking a child on the face or head.
- Any of the following intentional or knowing acts, with or without injury:
  (1) Striking a child age six or younger on the face or head.
  (2) Shaking a child age three or younger.
  (3) Interfering with a child's breathing.
  (4) Pinching or striking a child's genital area.

NOTE: The prior list of unreasonable actions are considered illustrative and not exclusive.

- No unreasonable action shall be construed to permit a finding of abuse without having established the element of abuse.
- Abuse shall not include physical discipline of a child when it is reasonable and moderate and is inflicted by a parent or guardian for purposes or restraining or correcting the child.
  (1) The person exercising the restraint is an employee of an agency licensed or exempted from licensure under the Child Welfare Agency Licensing Act;
  (2) The agency has policy and procedures regarding restraints;
  (3) No other alternative exists to control the child except for a restraint;
  (4) The child is in danger of hurting himself or others;

(5) The person exercising the restraint has been trained in properly restraining children, de-escalation, and conflict resolution techniques; and
(6) The restraint is for a reasonable period of time.

- Reasonable and moderate physical discipline inflicted by a parent or guardian shall not include any act that is likely to cause and which does cause injury more serious than transient pain or minor temporary marks.
- The age, size and condition of the child and the location of the injury and the frequency of recurrence of injuries shall be considered when determining whether the physical discipline is reasonable or moderate.

NEGLECT -- Acts or omissions of a parent, guardian, custodian, foster parent, or any person who is entrusted with the juvenile's care by a parent, custodian, guardian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, childcare facility, public or private school, or any person legally responsible under state law for the juvenile's welfare, but excluding the spouse of a minor and the parents of a married minor, which constitute:

- Failure or refusal to provide the necessary food, clothing, or shelter, and education required by law, or medical treatment necessary for the juvenile's well-being, except when the failure or refusal is caused primarily by the financial inability of the person legally responsible and no services for relief have been offered or rejected;
- Failure to take reasonable action to protect the juvenile from abandonment, abuse, sexual abuse, sexual exploitation, neglect, or parental unfitness where the existence of such condition was known or should have been known;
- Failure or irremediable inability to provide for the essential and necessary physical, mental, or emotional, needs of the juvenile;
- Failure to provide for the juvenile's care and maintenance, proper or necessary support, or medical, surgical, or other necessary care;
- Failure, although able, to assume responsibility for the care and custody of the juvenile or participate in a planto assume such responsibility.

TRUE -- Determination when the allegation of child maltreatment is supported by a preponderance of the evidence.

UNSUBSTANTIATED -- Determination when the allegation of child maltreatment is not supported by a preponderance of the evidence.